ORIGINAL

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

September 21, 2016
11:00 A.M.
James Thompson Training Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky 40601

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AGENDA

OLD BUSINESS WITHOUT COMPLETE RESOLUTIONS:

There is an ongoing request for Medicare denials from MCOs to allow for billing of services to MCO, although it is known now since 11 of 2011 that these services are not billable to Medicare and correct billing indicator is produced on bill to MCO..... 5 - 10

Prior authorizations for services requested: no rhyme or reason for authorization of "x" number of visits. Often do not match orders or complete weeks ..... 10 - 46

Switching of MCO mid-month for patients, lack of honoring prior authorizations, wrong addresses listed beginning August which are not corrected per request of patient/ family. Many of these patients are retroactive for months to another MCO without requesting to be moved. Providers can only provide assistance with guidance to patients/ families to correct. This has been occurring for months. What resolution will be provided? It is understood that this issue has been elevated to Commissioner level? What Commissioner and what was the communication? Will he communication be given to providers? ..... 46 - 62

Number and email address HH providers have been given: Numbers: 1-855-446-1245..... 62

Other contact information provided to HH: Medicaid Member Services: Email address for reporting MAP 552 issues and requesting assistance: MS.Services@ky.gov..... 62

DCBS phone number: For reporting to DCBS that you have to been able to obtain the MAP 552 or to see it/print it on KY Healthnet: 1-800-205-4696..... 62

DCBS has requested the following when contacting them for assistance with recipient issues: Name, MAID #, Social Security number, DOB..... 62

DCBS Commissioner: 502-564-3703..... 62

MWMA: As a reminder, if you are encountering technical issues, system error messages, or have general questions about MWMA, please contact MWMA/Partner Portal Contact Center. Representatives are available Monday-Friday, 8 a.m. to 5 p.m., EST, and can be reached at 1-800-635-2570..... 62

MS. BRANHAM: Good morning, everybody. Thank you for your attendance. I'm Sharon Branham, Chair of the Home Health Technical Advisory Committee. Today is September 21st, our last day of summer, and we are gathered today with an agenda to discuss issues home health providers are having throughout the state.

Please, everyone, note that if you have signed in for Terri's identification purposes as she is conducting the note-taking.

Just for your information, if you don't know, the agenda for today which is kind of small, along with the meeting minutes from our July 27th meeting are here on the back table for those of you that didn't pick them up.

So, I will call the meeting to order and I will start with a review of the minutes of the last meeting. And if there is no discussion or changes, then, I will accept a motion for the minutes as written.

MS. DYER: So moved.

MS. CARTRIGHT: I'll second.

MS. BRANHAM: Thank you. We'll start out today with our meeting agenda on trying to clean up some issues that are ongoing, and

it would be awesome if we could do an agenda and we don't have these longstanding issues coming forward from providers that I have brought to the table.

The first one is MCOs are still requesting with proper coding Medicare denials to allow for billing of services to MCOs, although the Billing Indicator 12 indicates that this is a non-billable service to Medicare.

Agencies have stated or providers have stated that it's very cumbersome to understand what to bill, what code to bill with and claims are submitted and then they are denied. And common examples are med presets and incontinent products, I guess, and those are the big ones, but the complaint and the general census when I put out a call for issues that agencies or providers are having, this was number one, and we've had this ongoing since we started with managed care for Medicaid.

So, I guess I'd like to have some advice from the MCOs how to tell providers to be able to complete the submission of this claim with known factors that it's not a covered Medicare skill or claim. I think everybody is using the same indicator.

MS. CARTRIGHT: Ours is with WellCare.

MS. RUSSELL: So, are you putting 12 in the Box 18 and you're still getting denials?

MS. CARTRIGHT: Yes.

MS. RUSSELL: Can you send me a copy of those examples, please?

MS. CARTRIGHT: Sure.

MS. BRANHAM: Are other MCOs also instructing us to tell providers that Box 18 with a 12 code should indicate to any claim submitted that this is a non-billable service to Medicare; therefore, it should be paid by Medicaid? And if so, then, I will do a communication to providers that they need to review their claims to be absolutely sure that in Box 18, they're putting Code 12. And if anyone continues to have difficulty with denials for those services rendered, that they should send directly to the MCO representative of each Medicaid MCO provider.

Is that a blanket statement that we can assume, Kathleen and Julie, is adequate?

MS. RYAN: This is Kathleen. I'm not familiar with the back-end claims processing

but I can check on that, but I just wonder, were there any particular claim examples that I could bring back and look at?

MS. BRANHAM: Well, I'm sure there are.

MS. RYAN: Okay. And, then, I would just also mention if the home health agency could contact their Anthem provider rep with any claims issues, then, we will look into it and get that addressed for them.

MS. BRANHAM: Julie.

MS. JENNINGS: I know that we have probably I would say a couple of months ago, we had a couple of claims issues come up with that exact scenario and we worked with claims and configuration to get that all worked out. And from what I understand, we haven't had any other issues to date. So, I would go to the same route as Kathleen is to get in touch with your provider rep and we will get those addressed as soon as possible there.

MS. BRANHAM: Anybody else from MCOs?

Okay. I guess at this time, then, I will request an updated list of our provider

representatives from each MCO so that I'll have that directly to communicate with my memo on proper billing. And, then, if further issues result, then, they will have that information to contact them, so, if you all could have that to me by Monday. close of business.

MS. BATES: Sharon, I just requested that from them. I can forward that to you.

MS. BRANHAM: That will be perfect. That way we eliminate. That will be perfect. Thank you so much.

MS. BATES: I'll just do it when I go upstairs.

MS. BRANHAM: Okay. And, then, that way, when I do a communication, they will have it. This has been ongoing. It's not new. Gosh, we provide lots of examples, but I really think it's time that this is cleared out on the back end of the billing process for all MCOs in regards to denials. We have been here since November I think of '11 and it's still an issue that agencies are having, and it does cause undue administrative burden on rebilling. And when you file your claim and it comes back as denied and you review it and you see that the

correct identification code is being utilized, it is frustrating.

So, Stephanie will provide me with the list of all MCO reps from all the different MCOs and I will put that as part of the communication on this example. And, Stephanie, I will copy you on that as well. Those change fairly often.

MS. BATES: They do. I ask for them every once in a while but I just asked for it.

MS. BRANHAM: Okay. Thank you. So, anything that I have from last month or the month before is outdated.

A prior authorization for services requested is an ongoing situation verbalized by providers to me when I put out a call for issues, and authorization on number of visits often do not match the orders or complete weeks. Some agencies receive more prior authorizations than others.

Is there verbiage that agencies should be utilized when calling MCOs to ask for prior authorizations because oftentimes if an approval is given for a skilled nurse to assess a

wound three times Week 1 and two times Week 2 and one Week 3, what is received is visits of a skilled nurse for three visits.

So, if you do those three visits that week, then, you have to call in on Friday to get your visits authed for the next week. And when you're writing, I guess the big issue is when you create your plan of treatment, the difficulty comes in when you are establishing that plan of treatment to be signed.

So, if you establish the plan of treatment that the physician must sign and we don't have authorization for those visits to continue, we can be out of compliance if, indeed, those visits are not received for us to conduct.

What happens is if the prior authorization isn't given for Week 2 timely, then, we have to construct what is a verbal order, and then we have to send that verbal order back to a physician because we didn't get a timely authorization for Week 2 and 3 of visits.

And this is a regulatory issue as well as a patient care issue, and we have talked about this along the spectrum of all different kinds of care that we provide, but when it comes to being

in compliance with being a certified agency, yet, not being capable of receiving the number of visits that are ordered, it does create an undue burden, and it also puts the agency in jeopardy for a condition-of-participation issue upon survey, not overlooking the fact that the physicians have to sign another document and we all know how that is.

So, we're looking for some opportunities to be able to construct our plan of care to agree with an order for particular needed visits when it comes to a fresh hip coming out or a wound or an administration of IV antibiotics. Those are the kinds of things that we are looking at when it comes to - and I know that we use InterQual and I know all those kinds of things - but when you drill down a little bit further, this really is the underlying problems that agencies are facing.

Any suggestions?

MS. RYAN: When we get a request, we calculate all of the number of visits for that time span. If there's any reason that we're giving less, then, it was either there was an agreement with the agency or that there would have been a denial because we would have to address the full number of requests. So, we won't reduce it for

any reason unless the agency is aware of why we did. Otherwise, if it's an approval for that case, we calculated the number of visits for that total time span and provided that in the authorization.

MS. BRANHAM: Typically our plans of care are 60 days and the physician will order what he believes to be the appropriate number of visits for the particular diagnosis.

So, the experience that has been fed back to me is you're going to have six visits, and I guess it's up to the agency to decide how they're going to write the order for the six visits which, again, it may only take you two to three weeks and then you have to call to get your authorization for the other visits and then you have to change your plan of treatment with verbal orders.

Billie I thought was coming.

MS. STEWART: She's en route.

MS. BRANHAM: Okay. She had some particular concerns which I'm sure she will provide, but I guess we want the MCOs to understand that when a prior authorization request is placed, it's not an arbitrary number. It's a number for what has been ordered for services. And if there is an agreement upon the number of services to cover a

particular time, then, the plan of treatment, in conjunction with a discussion with the physician, can be written that way, but understanding that our plans of treatment are 60 days and that if we don't have the services written for that amount of time, again, we have to amend it with sometimes up to three or four verbal orders to make us be in compliance with that particular patient's plan of care.

Does anybody else have anything to add, the home health folks here?

MS. BONSUTTO: I think you covered it.

MS. BRANHAM: And does anybody want to share any other information about the difficulty of having to monitor when you have an active patient requiring the services to get the authorization?

MS. STEWART: It's just labor intensive for something we should have gotten to begin with.

MS. CARTRIGHT: And if the patient has an issue and you've already used your visits, you go out and you take care of the patient and then you try to get the visit, sometimes that's

difficult to get that other visit approved, and a lot of our patients have difficulty with their IVs and have difficulty with their meds and there needs to be more than three or four visits.

MS. BRANHAM: Again, it's taking in the regulatory component of this versus--I mean, we're kind of used to labor intensive because that's what we do, but it is somewhat difficult to track that on top of everything else when you've got an active patient and service that you are seeing and you have the plan of care developed.

So, we were just kind of--well, we are requesting, does anybody have anything that we should do? Should we call and say we have a patient who has been ordered to have IV antibiotics times ten days and we need ten visits plus one PRN should their IV dislodge, particularly when it's somebody that you're doing either daily or two to three times a week visits on that we should say, hey, just to let you know, this is an IV patient and we've got seven days of visits ordered and we would like to have one PRN in case, because if you don't do it, you're not going to bill it, and you're not going to go out there just to stick them so you can get paid your $88.

So, is there anything that we can have an open discussion about where we can notify these folks that are on the front lines giving authorization in regards to, hey, can we do this, and if we need more, we will call back, or if we use less, it's not going to be billed?

MS. BONSUTTO: Sharon, I had a question because, Kathleen, are you the one that spoke earlier that said that if we have a full plan of care, we have the number of visits for the plan of care, that if we submit the full plan of care, then, your expectation is that we would get authorization for the full plan of care or get a denial and have an explanation why they're not paying? Is that what I heard you say earlier?

MS. RYAN: Yes. This is Kathleen. Yes, we would be clear on the number of visits approved, and if it is less than what is expected, we would discuss that. We won't just give you less and not have some communication if there's an appropriate reason. So, we address the full request.

MS. BONSUTTO: So, my experience is that I have almost never seen an approval for an entire plan of care in all my time,

and I have 20 locations across the State of Kentucky and we work with almost every MCO. What will happen is you will ask for 10 or 15 therapy visits and you will get approval for five, and the answer will be, give us an update after five.

So, there's no explanation of denial except that I'm not going to approve the full amount, but, yet, the physician has ordered it. We have it on the plan of care. So, now we have to go back and call again, get on the phone, send more documentation, all those kinds of things which costs the agency additional money which Sharon was talking about for administrative time and then processing all of that and making sure that we get them, but, yet, the doctor has said that it's reasonable and necessary. And if the plan of care is going to end early, we're not going to do those visits anyway.

But the claims that we're doing are not different than the straight Medicaid patients or our Medicare episodic patients which we treat them and trying to define that care all the same.

So, I think the issue is if the denial is, well, we just want an update after five visits, I don't think that that's an

appropriate reason and that's what I'm saying. It's not a denial of you don't think 15 visits for therapy are needed, and I can tell you in evidence-based practice, 15 therapy visits for say a hip patient or a patient who just got out of the hospital who is 85 years old would certainly be warranted and actually will probably decrease rehospitalizations than just doing five.

MS. BATES: So, MCOs by regulation are supposed to put the reason why something was denied on the denial letter. So, if you have denial letters that do not cite a reg or anything for purposes of a denial or quantity, less quantity or whatever, then, I need to see that because they have to put those on there.

MS. BONSUTTO: My experience has been that it's just simply we'll approve five and give us an update after the fifth visit.

MS. BATES: So, if that's all it says, then, I need to see it because it's not supposed to.

MS. BONSUTTO: Okay. That's been my experience.

MS. BRANHAM: That's everybody's experience.

MS. CARTRIGHT: That's my experience, too.

MS. BATES: That's good but I need examples of that.

MS. BONSUTTO: Okay. Sure.

MS. DYER: First, I apologize for being late.

MS. RYAN: I would need examples of that. I'm not saying that that is occurring, but I need examples to see if it is.

MS. BRANHAM: It's every request. Billie, would you like to address this?

MS. DYER: Yes. I'm sorry for being late but we had an emergency preparedness exercise this morning.

I have a whole packet that I don't really want to leave because I never get these back, but they are prime examples of the EPSDT Special Services Program mostly that exactly what everyone is saying is happening.

And, in addition, there is medical advice in these. Please, it looks like they would be more appropriate for "x" or please implement a home exercise program. It's on and on about medical advice in some of these. I'm a little

amazed or you've requested visits twice a week. I'm giving you four visits and try to make them work over "x" amount of months in some of these. And I don't know if the rest of you guys have seen this or not, but I'm pretty appalled that we're getting these. It's totally going into the realm of prescribing to me of what the patient should get from an actual doctor's standpoint.

And we're also getting occasional - and I can't tell you exactly the payor - but it's still cropping up that we're being required to send a doctor's signed order with the preauth request which I thought we had that all worked out but the actual signed order which delays the preauth, too. And I can send you, Stephanie, those examples if you'd like, but----

MS. BATES: Can I get them while we're here?

MS. DYER: You sure can. It's pretty amazing and it's keeping those kids from getting services because the therapists are getting calls and getting the orders bumped down and they don't need to be bumped down.

MS. BRANHAM: This is, I guess - I don't know - is this the first time you

all have heard that they have to have a regulation citing the reason for denial on the number of visits requested?

MS. BONSUTTO; I've not heard that.

MS. CARTRIGHT: It's my first time of hearing that.

MS. BONSUTTO: I just thought you could request and they could just say no for whatever reason and it's just been sort of standard protocol.

MS. BATES: It's on this one, but I'll look through them.

MS. BONSUTTO: I don't look at the billing. I don't get the billing, so, I would not have----

MS. DYER: Well, these are preauths. They're not the billing. It's the preauths we get back.

MS. BRANHAM: Is there a regulation cited?

MS. DYER: I don't recall one being on there. I could have missed that, there's so many of them.

MS. BRANHAM: So, my

communication to providers should be if you call for authorization of "x" number of visits according to the physician's order and the nurse's or the therapist's in-home assessment and the agency calls for a preauthorization and less visits are given than--preauthorization is given for less visits than what has been requested, that MCOs are to provide the statute for which the denial is based upon.

MS. STEWART: Stephanie, can I ask a question? So, there is a reg out there that says you can deny for a preauth for "x" reason?

MS. BATES: Well, like on these, they state the medical necessity reg as being the reason.

MS. CARTRIGHT: But does it spell out what it----

MS. BATES: And it doesn't have to.

MS. CARTRIGHT: Is it Milliman? Is that what they're using?

MS. BATES: Milliman or InterQual, depending on the MCO.

MS. CARTRIGHT: I would say most of them use Milliman.

MS. DYER: But, again, I don't

think that's looking at the program.

MS. BATES: Well, let me restate that. As of September 1st, it was contractually required that all MCOs use Milliman or InterQual. So, the contracts started July 1st and they had until September 1st, if they didn't already have those in place, to have in place September 1st InterQual or Milliman..

MS. DYER: Is that really something used for chronic problems like children with EPSDT Special Services? I think that's part of the problem because I think it's looking more at acute patients that we've talked about here, not the chronic, long term that you see in EPSDT Special Services.

MS. BATES: I don't know.

MS. DYER: And that's what those are.

MS. BONSUTTO: Are you saying that as long as that statement is on the bottom of that, that they're just saying it's because medical necessity but there's no explanation of what the medical necessity is----

MS. BATES: Right, and we see that across services, I mean, not just these.

MS. BONSUTTO: So, that meets the need? They can just say, well, it's because of medical necessity but there's no explanation of what the medical necessity is?

MS. BATES: And that's been asked that we've received here and through other channels and that is to give more detail into what's needed and we have taken that into account for the next contract year.

MS. STEWART: Which starts January.

MS. DYER: And we have looked at that and there's a lot of detail into asking for what's needed. We have internally looked at that.

MS. BRANHAM: Well, it's really not any different. I mean, if eight visits are requested for a skilled nurse over a 60-day period and an authorization is given for three and the rest are denied for medical necessity, really that doesn't deny because they tell us to call back to give an update.

So, they're not denying. They're using that as a blanket statement because they're not actually denying the authorization. It's just administratively we have to phone back to

complete the order as the order is written.

MS. DYER: Well, but it also does in many of those that I've handed off to you say please try to--it doesn't say definitely but please try to make these visits authorized last over this period of time which is a pretty extended period of time, way more than the physician has ordered for the duration.

Do you see what I'm saying? It might be four visits but please stretch them over maybe three months when it's twice-a-week orders or once-a-week orders. That's random. I'm not saying that's exactly what's said in there but that's the essence of what's said. It's just causing real problems.

MS. BRANHAM: So, when we call and ask for an authorization of four visits for the first week for antibiotic, for example, infusion, say seven and they say, no, we're going to give you five but you're going to deny because the medical necessity, that really isn't accurate because if you call back, you're going to get those other visits. So, they're not truly denying for medical necessity. They're just asking you to call back to complete your plan of care. They're not truly denied, but,

yet, they're using that blanket statement for a lot of times when we call in. They don't put the denial on there. They say call back with an update after you do five visits.

MS. STEWART: It's kind of like a loophole. If we don't get the call back, then, they deny us because we didn't have a prior auth. It's kind of like a loophole. And I think it's important the MCOs understand, every one of the patients we take we lose on. So, there's not a push out there for us to want to do excessive visits. We just want to do what the doctor has ordered.

MS. BRANHAM: And what the patient needs.

MS. STEWART: We don't make money on any of MCO patients.

MS. BONSUTTO: We would lose money. Even if we got all the authorizations at the very beginning and didn't forget to get one and nothing happened, that would all be; but then when the added administrative cost of having the clinicians calls back, time having to pay them, having to pay someone in the office - we have an entire administrative person just to do this. So, it's costing us thousands and thousands of dollars

that we're not getting paid for, and then all of the back billing that's going on with it, it's becoming to a point where we won't be able to care for this patient population because we won't be able to stay in business.

MS. BRANHAM: It really is becoming quite drastic. As agencies in the state unless you are with a large corporation, a large hospital group or a large freestanding group, it's very difficult to provide services because every time we walk out the door, we lose money, compounded by--I mean, we haven't had an increase since like 2001 or 2 and we're paid about $88 for a skilled nursing visit and I don't think anybody's cost is $88 for a skilled nursing visit if you were to pull the cost reports.

So, it is becoming and we're seeing this, whether it be an EPSDT provider or a Home- and Community-Based provider or a skilled provider, that it's becoming more and more difficult to care for the MCO population.

So, it's all great that acute services follow Interqual and this, that and the other, but it's really coming to where rubber meets the road when it comes down to these kinds of issues

that agencies are providing care for this population, and it's the vulnerable population. A lot of these Medicaid recipients come out of the hospital because if they're Medicare, that's where they're going. We can't provide Medicaid only now as in the past of personal care and those kinds of things, Medicaid only personal care authorizations for.

So, it's really where agencies used to care for probably about 30, 40% of your population on your active census was Medicaid and it's now, I think if we were to do an inquiry, it's less because we're not getting the patients to provide the services because people aren't taking them. They're picking and choosing because of the administrative burden that goes along with caring for the Medicaid population.

So, we're just looking for ways to get some kind of standard for approval of visits to decrease the administrative burden on agencies trying to provide care to this population. And I don't really hear that the regulatory listing for denials as on there helps us in any way because ultimately sometimes the visits are given and they're not totally denied. It may be less visits

but I think we're kind of back to rationing care for these patients rather than what is needed.

MS. RYAN: This is Kathleen with Anthem Medicaid, and I would just like to say that I do feel confident that our process is that if we're not giving you the full amount, we are explaining that. We do have to vet it for medical review and medical denial if that's the case and we will clearly document and notify you.

So, I would just like to ask for some examples because if there's something happening that is what you're saying, then, I certainly need to know about it. So, if you've got specific examples for Anthem, please let me know.

MS. JENNINGS: And the same as far as Humana-CareSource as well as far as my understanding is that we do not do that either. If we deny, we send it to the Medical Director for a decision, and then the official letter goes out for denial, but absolutely if there's examples of that, I would love to see it.

MS. DYER: This is Billie speaking, but I think that what happens with EPSDT Special Services sometimes, we see people in just traditional medical too, but we have such a large

amount of EPSDT Special Services that when the appeal process comes around, the family, it is a very convoluted appeal process that takes family involvement and they just get worn down or they don't know how to manage through that.

So, what has happened is less access to care. Our visits were down for EPSDT and my Professional Advisory Council wanted to know why, and I have to say that it's mainly because of what's preauthed. And it's not that we're trying, because they knew our program had grown. We have more patients on but less because people just get worn down with it. You get four approved and somebody is going to be on service for years and just trying to call back and call back is just more than people can do.

MS. BATES: So, this is a good segway into Senate Bill 20. We are so close, it's right here with the regs. Next week they should be final. We thought this past Monday. We had one more question internally. So, the regs will be final. I've already set up a meeting with the MCOs to go over the process a few weeks out because they don't know the process either, but that will be an extra avenue where providers can request that extra

step to try to get things paid. Maybe it will help resolve some of these issues. Maybe by way of the process, it will prevent even getting to the process eventually if the MCOs are found accountable.

And for those of you that don't know, Senate Bill 20 was passed back in the spring. I think it was like the third try or something but it got passed, and basically what it allows providers to have after an appeal where the MCO is upheld, so, it's not in favor of the provider, the provider can request an external independent review of the service that was denied.

So, then, that goes to an external entity. And, then, depending on the outcome, if it's found in favor of the MCO or if it's found in favor of the provider, either of the parties can then request a state fair hearing and this is on the provider side. So, actually the provider has more avenues than a member to get something paid, and usually most of these are going to be post-service denials.

So, it might help, and I kind of see it as a good thing. It might bring to the table issues maybe within the MCOs because if they start losing a lot of these, they will go back and

look at their policies so that way they don't have to do that because ultimately when it gets to the hearing process, the losing party has to pay for that but those regs will come out. When we get them final, we will send them out to everybody.

MS. BONSUTTO: Just the administrative cost of going through the appeal. So, you're saying we have to go through the appeal with the payor first.

MS. BATES: Has to do that first.

MS. BONSUTTO: And, then, after that. So, all of this money that we're paying, if we get through and we go through an external, independent review, who is going to pay us back for all of our administrative time and all of our stuff to get paid for something that we should have been paid for in the first place? There is no avenue.

MS. STEWART: Would it be a better request for us to give you examples of the denial of "x" number of visits, and, then, when you called back, you got the other, what you originally asked for approved? I think that's the better question is why didn't you do it in the first place.

MS. BATES: I mean, sure. If you have a way to provide that, yes.

MS. BRANHAM: Oh, yeah, we document it all, like who we spoke to, the day we called, the number we asked for, then when we're supposed to call back and what we're supposed to provide to further get the visits that were initially ordered.

MS. STEWART: Right, and I think that would be a better illustration of what we're having to go through and that might give you more insight.

MS. BATES: Yes, it would because that's not what is in these, even though this is good stuff, but just so you know, the regs are on all of these, so, there's that, but if you do have some that don't have the reg or whatever for citing the denial reason, then, I need to see those.

MS. DYER: So, is that recommendation allowed to try to make these stretch----

MS. BATES: I don't know. I wrote down to go back and toss that around because I don't know.

MS. DYER: That's really odd

to me. And Susan has a good point. Why all the hoopla if you're going to get them, but I will tell you that it's tenacity that gets you to get them because if people let down, you're not going to get the visits and that's what happens because they don't have the whatever.

MS. STEWART: One of two things happen. The provider provides the visits anyway and gets denied or the patient goes without care that was ordered by a physician. So, somebody is losing either way.

MS. CARTRIGHT: Right, and then they go back to the hospital and then that costs the MCO more.

MS. STEPHENS: And most recommendations like that would be from a medical review at the prior auth in order to approve it. So, we can certainly look at our process and see if there's opportunities there, but it wouldn't come from someone who isn't medically trained.

MS. STEWART: But do they understand--I would urge you to go back to those people and make sure that they're paying close enough attention to the request, that this is a home health request, not an acute request. There is a

difference. It might say home health PA on there somewhere but it's different.

MS. BRANHAM: Expound upon that, Susan, like you request IV antibiotics for ten visits with one PRN should something occur and you get five approved and you have to call back on "x" day to see if you can get the other five approved.

MS. STEWART: Exactly.

MS. BRANHAM: So, that's not going through medical review because they're telling you right then that you can only get five, right? So, that's not going to medical review.

MS. STEWART: Well, it might have gone to medical review before they told you you could only have five. Is that what you're saying happens?

MS. STEPHENS: I'm saying that people that look at prior auths has the training and the medical training and background to look at what's needed and medical necessity. So, they may be making those calls when they're reviewing those prior auths. Julie, do you have anything to add? We may have lost her.

MS. DYER: They may have the medical training but I don't know that - and we have

said this for a year or a year and a half but I'm going to say it again - that I'm still not sure the population served is being looked at and the chronicity of the issues in EPSDT Special Services. That's totally different, but when we get an IV patient, we usually get three visits approved.

MS. BRANHAM: Well, whatever.

MS. DYER: Whatever and you do just have to keep calling back, but we have to call back more and more and it is very difficult to get that to happen.

MS. STEPHENS: And I made a note to ask our team if they distinguish.

MS. BONSUTTO: So, what would be the medical necessity reason? I mean, you can say it's for medical necessity, but if the doctor has ordered ten days of IV antibiotics and that's the standard protocol for a round of antibiotics, what would be the medical necessity explanation from evidence-based practice to send back to us to say, well, no, you're only supposed to get three days? We all know that a round of antibiotics has to be for a period of time. If you don't, then, you're going to cause all of these super bugs to happen.

So, what would say, well, I'm

only going to provide three now except that you're hoping we won't come back and remember to ask for the other seven so you don't have to pay us for them?

MS. STEPHENS: We don't think like that.

MS. BONSUTTO: Okay. Well, then, what other reason----

MS. STEPHENS: We really try not to, but without looking at the case, I'm not a medical doctor, so, I wouldn't want to speak to that, but if you can give us some examples, we would be happy to look at them and review and we're always looking for opportunities to do things better.

MS. BONSUTTO: I've just been at these meetings for maybe a year now and we keep bringing packets of information and we keep sending things over. And, then, when we come back to the meeting, we start over again.

MS. BRANHAM: That's why these are old business without complete resolution that keep coming back on the agenda. If we have provided, and I'm sure we have but we will again, the opportunity for the MCOs to look at a plan of care prescribed by the physician and requested by

the provider to provide "x" number of visits and half of them were denied but not for medical necessity because when we phone back so that we can get paid for what we do and the approval is generally given, but it is mind-boggling to me that if a request is placed for addressing a wound, flush of a bladder, those kinds of things are, as Missy reiterates, evidence-based practices what should be occurring, it puts agencies in a situation that is harmful to them because of our certification and what we need to do for the patient.

So, we can give those to you all, and I guess I will put a call out for specific examples of "x" number of visits for an acute situation of a patient for a home health prior authorization whereby a certain number of visits were approved on first call and a certain number of visits were approved on second call which equal the initial number of visits approved.

We'll bring them or if I could submit them to somebody. And, then, what I would like to see occur is that at our next meeting, we have some concrete answers that relate to that and what kind of remedy we can have instituted to go forward.

MS. STEPHENS: And, Stephanie, will you be sending those examples? Are you the point contact and you will send them to us?

MS. BATES: If they're sent to me, yes.

MS. BRANHAM: Okay.

MS. STEPHENS: We will try to respond more quickly before the next meeting if we can get the examples and see what we can do.

MS. BATES: What are the exact questions that we need answered? That's what I need to know.

MS. STEWART: Why weren't all visits approved on initial request?

MS. DYER: Whatever program, whether it's traditional or EPSDT Special Services.

MS. BONSUTTO: Over and above just stamping the reg at the bottom of the statement.

MS. STEPHENS: And you guys are going to get specific examples to Stephanie?

MS. DYER: She has a whole-- well, see, the thing is, usually we get caught. We have a physician's order and licensure says that we have to go fulfill that order if we take that

patient. So, we're put--I mean, EPSDT, you lose money every time you walk out the door with EPSDT and so do we as a public home health agency because there's no cost settlement on EPSDT Special Services.

So, every time you go provide that service, you're losing money; and if you have to keep adding all the administrative to that, and the bottom line is they're still not getting what they need. It's so blatant in that program to me because there's so many other. I have a clerk that all she does all day long is work EPSDT Special Services, and a lot of that is preauth of the number again and the MCOs also require over and above what you have to fill out or send in a progress note with a preauth. Many of you guys require that if it's not enough to fulfill the state requirement of the progress note.

So, when you think that there's not lots of information given to try to substantiate why these children need visits, there's tons, and we have looked internally and beefed that up. I'm not going to tell you that it's 100% all the time because we're dealing with people, but we have looked at that internally and we are striving

to make sure that we do our part, but our part requires more and more layers of not just like a little blurb but we're talking about a whole sheet that is more intense than 30 years ago I filled out with an insurance claim to get billed when I was an office manager for a physician.

So, the amount that we're doing, it's unrealistic to ask people to do this for children that the doctor is qualifying to get those services. And that's what we're all advocating for, that we can continue to provide those services because we know they're needed. The doctor knows that. So, it's trumping what their doctor says. We've said that many times here.

MS. BATES: I don't know this, Sharon, but have you all made a MAC recommendation around this?

MS. BRANHAM: Well, I'm going to.

MS. DYER: I think you did the last time, didn't you?

MS. BRANHAM: Yeah, I did. We have made----

MS. RUSSELL: There wasn't a quorum last time.

MS. BATES: Right. If you did, I just didn't remember.

MS. BRANHAM: Well, we don't have a quorum. We have had at least three MAC meetings with no quorum because we have about five unapproved vacancies from resignations. So, we go. There's like six or seven of us that are always there. We talk about it and we submit it but no action can be done because we don't have a quorum.

We have one tomorrow and I think there's going to be six of us there, and they've added a second chair to the MAC for DME and that's not appointed. So, that puts that number even out there further. So, I don't know. I really don't know.

MS. BATES: I was just thinking an official, in addition to what we're doing, just an official statement.

So, just by looking at these, I know that it would be nice if the MCOs did give more, but regulatory-wise and contractually, the regs are on there but it's just the medical necessity reg. It doesn't say anything other than that but they don't have to do that right now as far as either the regs or the contracts.

And, so, what they have to do are they have to turn around prior authorizations within 48 hours. There's certain things they have to do that if they're not doing I need to know about.

I'm going to take back these where it says we recommend this instead of this thing. My guess is it will--I need to find the source, who is recommending that because it needs to be a medical professional of the same specialty and so on and so forth, not just a random person. So, I will check on that.

MS. DYER: And we have to remember, that recommendation is without assessing and evaluating the actual person which I think is a little--that's a little much to be able to recommend that, and it is a recommendation. It doesn't say absolute, but at first, my staff was taking that as an absolute. And I looked at it and I was like, wait a minute, we still need to----

MS. BATES: It still appears that that's what----

MS. DYER: It does, and people take it for that.

MS. BATES: I agree. So, I

will take that back.

MS. BRANHAM: So, I think if everybody is in agreement here, that I'm going to put out a memo that is going to ask providers to provide us with documentation on requests for prior authorizations for "x" number of visits from the physician for a needed service and the MCO has given "x" number of visits with a request to phone back to obtain further prior authorizations, and eight times out of ten, those were approved, and I'm going to forward those to you, Stephanie.

MS. BATES: Okay.

MS. BRANHAM: And, then, Stephanie is going to forward to the MCOs and we're going to see what we have with that. And if we can't get anywhere here, then, I will have the recommendation with the documentation to the MAC in regards to the declining authorization of services for people in need is basically what it comes to.

I guess if we were to look, and we all know about the Medicaid budget, we all know about the State budget, but I would also most suspect that the expenditures since MCOs have come in on home health has decreased drastically because we've always received prior authorizations, and they

were not nearly as difficult to obtain.

The back side of that is there's always financial audits conducted. So, if an agency was out here skip la de da providing all these Medicaid services and they weren't necessary, those agencies had to pay that money back if upon audit it was found that those services were not reasonable and necessary; but I bet you if we did some deep diving into that, you would see that that rarely occurred as opposed to what we're dealing with now. And I think providers are just like, you know, I don't know how much more we can do this.

MS. STEWART: We get less and----

MS. BRANHAM: Well, we get less reimbursement with, as I said, not an increase since the early two thousands and we have to fight for a patient visit every time we go out the door. And it's not because it's in excess. It's because we're trying to do the right thing for what has been ordered for the patient that is to receive the services.

So, with that being said, we will move on and we know what we'll do, and, Stephanie, I'll try to not bombard you with them.

Should any of that be redacted other than----

MS. BATES: Not to me.

MS. BRANHAM: Okay. I wanted to be sure. So, agencies would be asking that question.

Okay. Moving right along to Old Business is this mid month of coverage from an MCO for patients. In good faith, a patient is referred to a provider. The provider then checks eligibility. The provider receives a prior authorization. Services are provided. Claims are billed, only to discover that sometime in between all of this preliminary and necessary due diligence occurring, th1at the patient was switched to a different MCO. It could have been two months prior to when the authorization was given that we received and not all MCOs are honoring that.

This we talked about was occurring randomly, but I think it's more the norm than not. And, Stephanie, you told us I think in an email this week or the end of the last week that this has been elevated to Commissioner level. And my question is from the providers what Commissioner and what communication was given to the Commissioner

about what was occurring and has the Department put out any communication other than your email to us that we circulated to providers about how to remedy this or how to deal with this?

MS. BATES: It went to the Medicaid Commissioner, Commissioner Miller, and Veronica and Jill are Deputy Commissioners but it's a known issue. We've had issues with the systems switching around eligibility. I think I sent one back to you this morning that we fixed and it was a part of just the computers literally just doing it themselves.

And, so, when those issues are identified, there's a big a log of all the different types of issues that happen. They go back and do these big fixes. Honestly, it's not any of the MCOs' fault because they don't even know when they're being switched.

MS. BRANHAM: Right, right. I know. It's definitely an internal issue, but what's occurring is, like it's a wrong address or they were switched and reverted back to another MCO and that address is wrong. And, literally, an agency told me about a little old man that hired somebody to take him down to DCBS, waited there four hours, said it

was resolved. And by the first of the next week, it still wasn't resolved.

So, this affects not only home health providers but these folks that are out there trying to get their medication refilled and they can't pay for it. Otherwise, they wouldn't be on Medicaid. Pharmacies aren't filling their scripts.

I know a lot of us as providers are providing the service, but this is a huge, huge issue.

MS. BATES: I know. I get them every day. Just like what you send me, I get them all day every day and I send them on.

MS. BRANHAM: I guess the communication out to the provider world is really lacking and I brought this up at a MAC about----

MS. BATES: That was your other question. Nothing has been communicated out that I know of officially.

MS. BRANHAM: Well, I brought up at the MAC, I don't know, it's been at least two meetings ago, maybe three to Commissioner Miller that we used to get provider letters routinely, and those were something that we all kept and kept in a notebook and that's what we referred to, but the

communication is just really nil and not everybody gets--you know, you can send it to me and I can send it to Ned and we can both send it out, but really not everybody that provides home health services are not adult days and they don't always all get the communication.

And those transmittal letters when there were changes and communication that was occurring from the Department were generated to everybody that had a provider number that it affected and those have been gone now for quite some time.

And Commissioner Miller came up to me after the MAC and agreed and said they were going to do better, but I think some of these things are fairly important that need to be communicated and it's not because, I mean, now it's like, you know, even people off the street have heard that they could call me and I could see if I could get their address, you know, alert you----

MS. BATES: Well, imagine if you were me.

MS. BRANHAM: I know. I cannot even imagine because I have people saying, you know, I heard you could tell me how I could get

because I spent two hours on the phone and they said it was fixed. They would put in the fix request. And, then, the next week, you know, they go to try to get their medicines filled that week and it's like, sorry, it's still not updated in the system. I mean, this is out of control.

MS. STEPHENS: Is that lumped in with the Benefind issues?

MS. BATES: Yes.

MS. BRANHAM: Was this from kynect to Benefind that caused this?

MS. BATES: So, I just wrote down, for my take backs, I will ask about that, if there's any way that we can send a provider letter around all of these eligibility issues. There are so many different--they've all grown wings.

MS. BRANHAM: I feel like the AFLAC. It's like Medicaid is the AFLAC duck. You know that commercial where he's in the boat and there's a hole here and a hole there and a hole here and a hole there and that poor duck is trying to, and then finally he sticks his head in the bottom. We get one hole plugged and there's ten or more coming. You all are not really capable of getting all that together for it to matter.

MS. BATES: I wish it were me.

MS. BRANHAM: Well, I mean, you know, like for people that are out there that literally because Benefind wanted to change their address that they can't go get their medications filled. Heck, if it's the same person with the same Social Security number and the same date of birth, what does it matter what the mailing or the physical address is?

And this affects pharmacy, I'm sure hospitals. I know it affects home health providers. I mean, it's really huge. I mean, it's the same person. There's their picture. There's their card. There's their date of birth. There's their history in the system with their MAID number, but, oh, my God, somehow a physical address versus a mailing address got switched and they're stuck.

You can't get through on the 800 number. You can't get anybody to answer your emails. You can't go to the DCBS office. I mean, all of that was taken away, and I really feel bad for these folks that are out there relying on this being their medical care when it's a glitch like a physical versus a mailing address.

MS. BATES: I agree.

MS. BRANHAM: I mean, we've been saying this was happening and now it's huge, huge. I don't understand why there can't be some kind of, until this mess is lined out, it's like if it's the same person with the same date of birth that has a history that they've had Medicaid for a year, they're still eligible but it has the wrong address. It's huge. It's huge and nobody can fix it. You and ten people if you worked all day, you all couldn't get all of it corrected.

MS. WELLS: If I may, Stephanie.

MS. BATES: Please.

MS. WELLS: I believe the Cabinet is well aware of all of these issues across the board. They're not just affecting home health clients. They're affecting all individuals who access Medicaid.

MS. BRANHAM: Oh, I said that.

MS. WELLS: And, so, the technical assistance entity within our Cabinet as well as Deloitte who created the system on behalf of our Cabinet is aware of that. And, so, they are putting in fixes to sync better the data that is from all the different systems such as MMIS and

KAMES and all of that. Obviously as you know, they're not, per se, communicating well based on all of the holes.

And, so, there are syncing components that they are doing over a course of time over this month going into October that should hopefully rectify the majority of these. There's still going to be some because there's also humans involved in that and having to enter information as well as clients and citizens having to go down and clarify their financial eligibility as well.

So, those things that were always in place are probably still going to be barriers for some individuals, or those that move regularly and don't update everybody, but it is recognized.

And, so, there is a plan in place to remedy this problem. It's just going to take a little bit of time because there are lots of holes, as you've indicated. And, so, hopefully their goal is by the end of October, that the majority of all of this should be completed and that the individuals who are hopping in and out or one day they're eligible after you're providing services, and the next day you go into Kyhealth.net

and they're not there, those things should hopefully be remedied.

MS. BRANHAM: Why couldn't they extend authorizations for a bad address? Like, if somebody is eligible and there's authorization but providers can't bill because of the bad address, why couldn't an exemption be put in?

Say if you all think it's going to be the end of October, then, it will probably be a little bit longer than that if we follow our history, that until the end of the year, that a good PA is a good PA no matter if it's got the wrong physical or mailing address of a Medicaid recipient because, as you said, they move around.

MS. WELLS: I will just speak to this because obviously this is more of a DCBS component that we're moving into and none of us on this side are with DCBS, so, I'm not going to even try to speak to them, but there's a purpose of knowing exactly where this medical card is supposed to be mailed and all of that. So, there is some onus on the individual.

I know that there are individuals who have barriers to being able to understand and facilitate that component, but if

they choose to move or do all of that, they do have a responsibility in which to provide that correct information back.

And, so, yes, I understand as a provider, that does create a barrier for you but they----

MS. BRANHAM: But what if they're still residing in the same place and it was----

MS. WELLS: Well, and those are the things that hopefully will be, you know, because, as you know, in one system, it may say something and then someone else may have something else. So, those are the things that are going to be fixed; but in regards to extending PA, there's a lot of components that obviously would be very helpful for a provider, but if we're not fixing it on the front end, it creates a lot more issues also down the road, too.

So, I think what just needs to be the take-away on this subject only is that we're aware of it and we're putting in processes to fix that and that's really all we can say that hopefully it will be remedied to better satisfaction over the next couple of months.

then maybe like when I see fixes go in, a couple of more come up. So, it goes down and it comes up a little bit and it goes down and it comes up a little bit. So, it's just like what we were talking about. So, hopefully over the next little bit. There's progress being made. It's so frustrating, I know, for providers and for members and for us.

MS. BRANHAM: We deal with the frustration level up here every day, but it's the patients out there that need their services and need their medicine.

MS. BATES: I know it's not that helpful, but anything that you need fixed right away you can send to me and I will do everything I can to get it fixed.

MS. DYER: First of all, we don't have the ability to check every day. And you may not realize it like a hospital, Tonia, but hospitals evidently have an ability to check every day very easily through a system that I'm not aware of. We have to have somebody manually go in through a clearinghouse or through Healthnet. We've switched to a clearinghouse to try to free up our time but we can't check all our recipients every day.

It's humanly impossible to do

MS. BRANHAM: Well, I feel sorry for those that are relying on getting their medication paid for by Medicaid because they have lived there for 50 years and a computer glitch caused the wrong address that they can't get it. That's just the reality. I don't know what they're going to do.

MS. STEPHENS: I know a lot of work has been done on this over the last couple of months on Benefind and it's greatly appreciated. I know there's a lot more to do. You mentioned that they have a daily issues' log. Is that something that could be--to get the information more quickly, is that something that can be shared with the MCOs so we can kind of be proactive on getting it corrected or is that not a great idea? I know we have to wait for the file, but I guess I'm just trying to think of a way maybe to get that process started faster.

MS. BATES: I don't think so.

MS. STEPHENS: Okay. I was just curious. Are you seeing the number of issues go down with all of the work that's been done over the last couple of months?

MS. BATES: It goes down and

so, but, secondly, and, Tonia, you're kind of new to that, so, you might have thought we could like a hospital and we can't.

MS. WELLS: No. I was just speaking to that we're aware of the problem and we're trying to fix that.

MS. DYER: But just for clarity here, that we have to manually provide that within our agency. But, secondly, I think for what we understand or what I understood from the letter, Stephanie, when we have sent people, we're to assume that that's going to be fixed and just go on like----

MS. BATES: Are you talking about the address----

MS. DYER: Yes. Well, the whole switching from Medicaid to an MCO or an MCO switching, all of that switching, we're still to go on and assume that the one we think is, we just continue in that and you're fixing it and we have had results with the fix because staff has asked me that, well, do I wait to hear? Do I have to stop services or put them on hold, call the doctor.

But I think that what we got from you and what's working out is that we're going

on and providing the services under what we know it to be and, then, when it gets flipped, you guys are fixing it back. Is that what we should assume to do?

MS. BATES: Yeah. I usually always try to communicate back when I hear back on the fix. And sometimes if I forget, just remind me because I get so many and I might have thought I had already done it.

But at the end of the day, I can't tell you that if a member is showing that day ineligible or something is wrong and you've asked me or someone else to fix it to go ahead and give the service because I don't want to be the one--I don't want it to come back that, oh, Stephanie said go ahead and do it and you'll pay for it.

MS. DYER: I think we need that answer from somebody, and I didn't know if you could say that or not. I don't know how everybody else feels but we really need to know that, and that's kind of what I took from the letter and that's honestly what we've been doing with whatever chance there is out there; but at the same time, I know it is getting fixed when they send it to you and I think we have another contact and I said

Stephanie still has to know because you really need to know how much it's happening, I think, anyway.

MS. BATES: Well, that and it goes to those people that keep that issue log because some of them they might think it's fixed and it's not fixed. So, I want them to know that it's not fixed.

MS. DYER: So, that's what I've instructed because we got another contact's name that was fixing really quickly, but at the same time, I said do not leave you out of the loop. That's what you want us to do, right?

MS. BATES: Right. Just that way I know it's going on that log.

MS. DYER: But if you could take that on up that we need something----

MS. BRANHAM: And then give us some communication, Stephanie, about that because, in good faith, we are saying this has been discovered. And generally it's on the back end when we are billing for the services, okay, and it was like, oh, they were retroactive five months to another one. Well, how did we even check eligibility because we do check eligibility every month. Wonder why it doesn't show up when we check

that eligibility at the beginning of the month?

MS. DYER: Well, I think we finally figured out the answer to that. If you don't put the range that you're checking back to your last check date, you're not going to pick up. If you do that, you will see where it changed.

MS. BRANHAM: But you can check two months----

MS. DYER: But if you just check for--like, we were checking at the beginning of the month because that's what we had always done and that worked, but if we didn't put a back date of more than a month, we weren't picking up that something happened until it got billed.

Now if we put in a date longer than 30 days, we're seeing there's an alert that's coming up. Well, we're using a clearinghouse. So, with that clearinghouse, there's an alert that's coming up that something switched; but because we were doing what we have done for a hundred million years and put in from the 28th to the 2nd or whatever they were doing like that very short time period. So, if you don't go back the whole month and we didn't have----

MS. BRANHAM: But it also has

occurred that you were paid by an MCO last month and then you check and it's that same MCO this month and then when you do your billing, then, it may have reverted five months. So, you can't capture all of that all the time.

MS. DYER: Well, we just discovered that to see how much that might help us, but we did find that if you put in the 31 days back, then, you might get the alert quicker that there's a problem. It might be helpful because it sure is better to find it out then than on the billing end. It takes a lot more on the billing end.

MS. BATES: I'll take it back and I'll see if I can get some official go ahead and see them, don't see them or whatever.

MS. BRANHAM: So, again, I included in here. So, if you all could just do a quick, Stephanie, about the providers, the numbers that they have been given that goes to DCBS and Healthnet and all those for assistance.

MS. BATES: I'm going to take it upstairs to make sure that they're all right, if you don't mind. I can email you. I just don't want to say right now without checking.

MS. BRANHAM: Just so we can

put that in a communication, too, if anything has changed.

MS. BATES: And there might be another number, too.

MS. BRANHAM: Any other questions on old?

Well, let's move to some New Business, and I think since I developed this Sunday or so, we've had a couple of things come out via communication from Tonia on the first question and a little bit more guidance about the testing for attendance. That came out.

MS. WELLS: There's no----

MS. BRANHAM: Well, we didn't know that until now. We didn't know if people were going to apply to do themselves to take the test and then tell an agency that we have taken the test or did the agency establish the information for the test that are going to be attendants or these folks that need to take this test. There really wasn't any clear understanding from providers about how that was going to actually occur. So, that's why.

MS. WELLS: I'm surprised at that. I explained that I thought quite well in the training. So, I apologize that you all did not feel

that that was adequate. I hadn't gotten any questions about that, but hopefully after my email yesterday, it is understanding of how that should work.

MS. DYER: We'll try it and see and test it out.

MS. WELLS: I may have misnumbered one of the numbers on the test. Someone wrote back and said that there's no #9. So, I might have to send a new test out. I don't know why. Maybe I don't like the #9.

MS. BRANHAM: Well, in the communication and in the trainings it said a test was being developed and they would take this test online and that if you used a worker, they had to have this test, that certified people were not even exempt and that kind of thing, but I didn't really understand exactly how that was going to work. That's what was communicated to me when I put the questions out to the list serve.

MS. DYER: You mean whether you could use your own training or try to see----

MS. BRANHAM: No. We knew it was a State-mandated test, but we didn't know that----

MS. DYER: No. We can submit what we do and see if that works, but we decided as an agency to do what we do for the 12 hours of training or whatever in-services we do and just go ahead and do the DAIL training because I think that's going to be easier because you have to submit what you do to get approved to you guys, right?

MS. WELLS: Correct. And we've had I think three or four home health agencies already do that and that was discussed at training. So, adult day health as well as home health agencies were able to submit the training that they already had produced and our understanding was that it was possibly from the Home Health Association or something along those lines that they had given out.

And, so, once that training is sent to us per that individual agency, then, we compare it to the components that were outlined within the reg that needed to be met; and if they do, we let them know that, or if there's areas in which they don't, then, they can re-send us some other information - maybe they didn't send everything - or they can use those components within the training to address those issues that maybe their individual training does not already have and,

then, they would just work with us on that.

MS. BRANHAM: We hire somebody to do training for the association membership that writes the education on a monthly basis. And for ease, it would have been, if we would have known that those components could actually work, we could have submitted our entire education component to see what matched and what didn't match. It's kind of like double work.

MS. WELLS: Well, we did. DAIL did reach out to the association. It might have been this young lady right here in the pink. I don't know who it was, but Phyllis Colt reached out and our understanding was that there was not necessarily a training module available and that that was a work in progress and things along those lines, but we did reach out.

MS. BRANHAM: Yeah, I saw the email that said do you all provide training, and we were like yeah, but we didn't know that if we worked hand in hand, it could have been something that----

MS. WELLS: Well, our training is not for just home health agencies. It's for waiver, direct service providers. And, so, we needed to look at the entity that provides all of

that type of service. And, so, I don't think it would have been fair to utilize the home health agencies' training modules. I think what we wanted to do is----

MS. BRANHAM: Oh, I didn't suggest that. I suggested that, again, communication and collaboration, we could have been on the same page because this is something that has been going around for quite some time, and we just got that yesterday. So, all I'm saying is it's a lot easier to work together and have open dialect about, hey, you all do training. Can you submit your components and let's see if that's good and, then, you all can go with that. And, then, if you've got anybody else and they can take this, I don't know.

I just think that's how agencies feel a little bit of frustration about not adequately understanding where we are. That's what has been communicated to me. This isn't just my convo. This is conversation from providers, Tonia. So, that's all we're saying.

MS. WELLS: Well, I would just reiterate that they know how to contact me personally and I would be glad to work with any of

the individual home health agencies on any of those issues. Amy Moore is also here and has been working with them. So, I think for the entities that are expressing frustration, I don't believe we've heard from them. So, that's unfortunate.

MS. BRANHAM: Well, as I said, we have been gathering questions prior to this. And last night, the education came out or yesterday.

MS. WELLS: Right, but I believe that, Sharon, I have been updating with email, and I feel like we're just going tit-for-tat. So, I don't know if this is productive or not, but in the email and in the trainings, we said that it was going to be delayed and that we would get it out as soon as possible, and, then, there were some other emails that I have written and Amy sent out through the list serve to kind of update you of where that is. And, then, our last email prior to me sending it out was that whatever did go out, you would have basically 30 days or a month to get that done.

So, I think we recognize that were delayed in having it prior to the 15th of HCB II going live, but I think we tried to communicate that it was going to be delayed and that we were

explaining that there would be a grace period for those employees working with individuals who are recerted to give them ample amount of time to complete that, or if an agency provider would like to send in their information, we would be glad to look at that.

So, I mean, I feel like we've tried to be as transparent as we can. Obviously we didn't make the mark based on your provider feedback.

MS. STEWART: Has anybody submitted what the Home Care Health Association does?

MS. WELLS: No. You know, I can't speak to whether it's from the Home Health Association, but we've gotten many agencies - and I'm not going to name them because I don't think that's fair - but we've gotten large agencies' information. And I don't know if it was a collective component, their own in combination with the Home Health Association or if it's their own corporate. I couldn't speak to that honestly.

MS. STEWART: So, no one said this is what the Kentucky Home Care Association----

MS. BRANHAM: We weren't

asked. That's my point. Okay. So, that actually takes care of the update on the applicants and who passed the test and hiring will provider names be given. That takes care of that because, as I said, this was kind of developed before.

And, then, we did have a list of providers that Amy put out of case managers and providers in a zip file. And I don't know if Amy and you all have had contact and requests, but some folks have had some negative comments that relate to the fact they couldn't open it and when was it coming and lots of IT issues.

MS. GERVAIS: I had a number of providers that couldn't open the zip file. It wasn't just the one that we were communicating with. So, I have had to send them a link to a drop box and that seemed to work where they could open the file.

I have also forwarded an email message that did include an attachment about a month ago. And in the attachment, some of the providers were saying that there was a virus in the attachment that had come out from the ky.gov.

MS. WELLS: I don't remember that. Could you re-send that to us? I don't remember. Amy looks at the inbox. Did it go to the

DAIL.hcb? Did you send it to that or did you send it to us personally?

MS. GERVAIS: No, I didn't. I didn't forward any of the information because I was afraid to keep forwarding it if it was infected.

MS. WELLS: Right. We had not heard that from any of the other, any feedback. So, if you would like to send something to us so that Amy and I can explore that but we were unaware of that.

MS. GERVAIS: Okay. I will do that.

MS. BRANHAM: How do you all feel about the coverages for waiver throughout Kentucky as far as providers and case managers and just a general update about how that is going?

MS. WELLS: I feel that there is availability in every county for individuals to have some type of choice.

If we're speaking from a home health entity component, then, most home healths have chosen just to do case management. So, that is obviously their business choice and we recognize that as what it is.

Other agencies and entities

have stepped up and have opened up their doors to provide attendant care in those counties. So, we do have coverage in all 120 counties for attendant care on the traditional side.

And, so, I feel confident that individual will have options, but will it be a lot of choice? No, but I think we do have coverage in all 120 counties for attendant care as well as, of course, on the PDS side and respite. So, for the traditional side which you all mainly dive into, we do have someone available to provide attendant and respite for all 120 counties.

MS. BRANHAM: Good, because you hear different things about I'm not providing, I didn't provide, we're not providing, dah, dah, dah. So, I just wondered how the Cabinet felt about it.

Is Lori in here? No. I sent the agenda, and yesterday I received--let me see if I can backtrack this a little bit. I sent the agenda to our committee and asked them to review to see if there were any further issues to be included.

There's one addition but I had already submitted it, and it was a question about prior authorizations on patients transitioning to HCB versus HCB II, whether or not their current PA

will be extended 30 days, these patients that will be reassessed by the HCB versus HCB II DMS nurses.

And Lori answered yesterday in an email that prior authorizations for individuals who have had their level-of-care days extended also have had their prior auths extended to coincide with those dates. So, their current services will continue until a new level-of-care determination and a plan-of-care approval happens.

In regards to the different lists, many of the differences are related to individuals who were discharged from the waiver and either the list was created before this occurred, so, it wasn't captured or it hadn't been processed through MWMA at the time the list was generated.

The list that the nurse assessors are using is from the MMIS and it lists everyone who at the time the list was generated had a level of care for HCB Waiver. The assessors are comparing the entries with what is in MWMA and submitting those to the system. We are keeping track of individuals who we were unable to contact who are noted to no longer be receiving services and we'll be working with MWMA staff and HP to ensure that these individuals are removed appropriately.

MS. DYER: That was my question, and then it came dup with Kristen yesterday, and actually it's the reverse of how that has been answered. We have more than the assessors have. Kristen always is having additions.

MS. WELLS: So, the individuals that had recerts before or after the 15th, your list is bigger?

MS. DYER: After the 15th, the people that are due for reassessments----

MS. WELLS: From the 15th forward.

MS. DYER: Yes, when she's talking to the assessment nurses, we have more on the list than they have. So, she's calling. So, that's a good thing, but we haven't heard from the nurse that covers Powell County.

MS. WELLS: Can you send that list that Kristen has?

MS. DYER: I don't know if we can or not. Who do we send it to?

MS. WELLS: Well, you can either send it to me or you can send it to Lori. I mean, ultimately I would get it to Lori Gresham.

MS. DYER: We can just send

our waiver list, period. I mean, we could just do that, our whole census of waiver.

MS. WELLS: That's fine. Do you have their recert dates on there, their LLC dates?

MS. DYER: She did have. She probably does have that.

MS. WELLS: You could do that because they should show up. I mean, what you have obviously has a PA and an LOC and they're pulling that information from CareWise, HP as well as the MMIS.

MS. DYER: Because I thought it said it came from all sources and they would definitely have the comprehensive list.

MS. WELLS: Right. So, if there's a discrepancy there, if you could send that, I think that would be helpful because she only knows what HP, Carewise and MMIS----

MS. DYER: But it might be just as well if they contact us all as the assessment----

MS. WELLS: And they're planning on it.

MS. DYER: Because they could

be closed by the time that the assessment comes around. So, the communication is the best way actually.

MS. WELLS: I think I'm now confused, Billie. So, the people that----

MS. DYER: The concern is that somebody is still not--we brought this up because I'm sure everybody else might have it. We haven't heard from the Powell County nurse assessor, but the one from Madison and Estill we have heard from, and she and Kristen are reconciling their list and that seems fine, but others may not be aware. If they're not getting calls----

MS. WELLS: I think the nurses are--I'm sorry. Go ahead, Alisha.

MS. CLARK: I was going to say if you can send that list, just send the issue and what your concern is to Lori so that she can reach out and make sure----

MS. DYER: Who is Lori?

MS. WELLS: Lori Gresham. I'll send you her email or I'll send her email to you, but my understanding and from what Lori has communicated to the HCB team is that they are confirming those lists with all of that but they are

going in chronological order of the LOC's. So, I don't know when Kristen's recerts are, your social workers' recerts are.

MS. DYER: She's got them all mapped out. We definitely have that information.

MS. WELLS: So, I can't say why she has called one county and one not but I know they're going in chronological order of when they're due and they're working their way through those, but I still think if you----

MS. DYER: Well, but I think it's more information to you guys that that's inconsistent. I think we've got the list and Kristen can forward our whole census when they're due. I mean, that's not an issue to forward that to Lori. We have to use something called Box. We can't email within our agency and we're sending you guys an email saying we're dropping you something in Box what's confidential. So, when you get that from Medical Home Health, it's for real but we can't send those in emails. We're not allowed to in our agency.

MS. WELLS: Right. You don't have encryption.

MS. DYER: We do not. So, we

have to send it that way.

MS. WELLS: That's fine. She sent a couple of other things.

MS. DYER: Is that working for you?

MS. WELLS: Yes, as far as I know it has. I mean, I know I looked at the last thing she sent.

MS. DYER: I'll just get her to send our whole census.

MS. BRANHAM: Rebecca. Missy, have you all?

MS. BONSUTTO: I'm asking that question right now.

MS. STEWART: We have so few, it's irrelevant.

MS. BONSUTTO: We have a ton. My guess is they're probably communicating with these folks because we have a large number but I will verify that.

MS. DYER: Well, there's gaps of what the assessor has and what we have.

MS. WELLS: I think the one point that I think I'm confused on, Billie, is you said they're on your list but they may be closed.

MS. DYER: By the time that the reassessment would be due they might be closed. Like next March, they might be closed or something by then. Do you see what I'm saying?

MS. WELLS: Okay. I think as long as you----

MS. DYER: I mean, they're not closed now. We have an active list.

MS. WELLS: So, on the list, whatever the spreadsheet that Kristen has, if it could just make sure it has the LOC dates on there and their names, that would be perfect.

MS. DYER: Is that the reassessment due date?

MS. WELLS: Yes.

MS. DYER: All right. She can just send all of them. I'll send them all at once.

MS. WELLS: That's fine. If it's a spreadsheet, they can forward it.

MS. DYER: It's not a spreadsheet. It's a census list.

MS. WELLS: Is it by month or just random clients?

MS. DYER: It's just the clients.

MS. FLYNN: With the date written beside the client's name.

MS. WELLS: Okay. We'll figure it out.

MS. DYER: And you can call Kristen.

MS. WELLS: Lori can match that up against theirs. So, obviously there's going to be some----

MS. DYER: So, if you could send that answer on, then, I'll send that to Kristen because I think she missed the point. She just answered it reversely from what Kristen was asking.

MS. WELLS: I did want to speak to one other thing, the extended PA's. Those are just for individuals from September 15th to October 14th. So, those are the only individuals on your censuses - is that a word? We'll see how it comes out typed, right?

MS. DYER: So, not to the end of October, just to the 14th.

MS. WELLS: Just until the 14th. So, those individuals were given a 30-day extension, just those individuals.

MS. DYER: I think that's what

Kristen is worried about, that we're coming up on hearing nothing and she just worries about it.

MS. WELLS: Like Darlene had six that were not given out of her entire organization. So, we need to extend those, so, we're working on that. So, there's a couple of other, like there was one at an Area Development District. So, there's a few that were not extended that PA even though they're in that group. And, so, if agencies are aware of that, then, we just need to be told so we can go into the system and extend that.

MS. DYER: So, you want us to send those names through Amy to you all?

MS. WELLS: I'd prefer that you send them directly to me, but just clients that are from September 15th to October 14th are the ones we extended, and they will stay within current PA and current plan until they are switched over with their PA. Even though they may have a level of care approved, they're not going to be switched over - and, Darin, help me make sure I say this correctly - they're not going to be switched over until they have all of the prior authorization from the person-centered plan. So, you will continue to work with

their HCB I 109 until they're completely through the prior authorization process through HCB II. Does that make sense?

MS. DYER: Through the 14th of October.

MS. WELLS: Yes. So, hopefully you won't need that whole 30-day extension. Hopefully you wouldn't need that full 30 days, but for some reason if it does happen, that was the purpose.

MS. DYER: Okay, and I think we understood that but she's getting some and not some. So, she can send you what she does have.

I have another question.

MS. BONSUTTO: All of ours have heard from the nurse assessors. They say they're struggling with the process but they're trying to work through it. And I let them know if the PA's, they didn't get them, to send you in a secured file.

MS. WELLS: Excellent.

MS. DYER: I have another question that you may have to take back to somebody to address and I've not heard this from you but it was from somebody else. We share things in the

Kentucky Public Home Health Alliance, information quite a lot, but there was an email that Kristen had been emailing back and forth with another nurse administrator about our internal policies and our manual that we're putting together and the whole nine yards.

So, the other person did send up a question about her training and got back something to the effect of this, that home health aides - that's who we have to provide attendant care - but whoever provides attendant care is going to be required to document progress toward goals.

Do you know anything about that because that's not what aides do?

MS. WELLS: So, under the final rule, I think----

MS. DYER: Do we have a copy of the final rule? That got me, too.

MS. WELLS: You can find lots of copies of that large document in various places, but within the final rule, there are certain CMS - and, Lynne, please keep me correct if I misstate - but there are certain components that direct service providers or any provider has to meet from a CMS standpoint - time in/time out, name, title, make

sure they write a title - if not, give them one - home health aide works. For waiver, it would be attendant care worker, respite worker and the date, but within the note itself, there are some things that have to be addressed.

One, what service are you providing, not saying attendant care but what things did you actually provide. I helped them with their bath, I helped them get dressed, things along those lines, and those all are related back to the person-center plan which, as you know, has goals and objectives on that.

And, so, obviously if you're in a waiver, you're working toward those goals and objectives that are written on the person-centered plan and that direct service provider should be working on that. Hygiene could be one of those goals and the objective is to make sure that they are clean and bathed three times a week or something like that - I'm making it up as I go - but something along those lines.

So, those notes that the attendant care and the respite worker will have to write that service documentation while they're under waiver providing those services.

MS. DYER: Well, here's the problem. Most everybody I know has an electronic medical record, some do not, but they don't write those. They use a telephony note that is a checkbox. They don't write a narrative. They use a telephony note that is a checkbox. So, they don't write a narrative. So, we don't have our aides document--the person that would evaluate----

MS. WELLS: So, is that on the skilled side or in the waiver?

MS. DYER: Well, in the waiver, the person that would document against progress toward that would be the supervising nurse or the case manager. The aide would just simply say what they were able to accomplish.

MS. WELLS: By checking a box.

MS. DYER: Yes, or the reason why or they do a case conference note of something abnormal and go through all of our process to notify someone that something was askew that day.

MS. WELLS: Okay.

MS. DYER: So, it's really not, I don't think - everybody else can speak - but it's not in the scope of an attendant to document toward progress that we can ascertain.

MS. WELLS: I'm not saying document toward progress. You have to document about working toward----

MS. DYER: But that's what this person just said.

MS. WELLS: You have to document that you worked on that goal.

MS. BRANHAM: We are providing an order.

MS. WELLS: So, under waiver----

MS. DYER: A goal or a plan----

MS. WELLS: So, as you know-- let's just back up. As you know, on the 109, as well as in the MWMA and the person-centered plan, all individuals have goals and objectives.

MS. DYER: I'm trying to be with you.

MS. WELLS: Because there's things that they have to work on and meet to obviously be in the HCB waiver or any waiver. Individuals who are direct service providers - attendant workers, respite workers - are responsible for working on those things, that they go out with a

purpose. They just don't go out and just say I'm here. They go out with assignment, correct?

MS. DYER: We get that. I totally get that.

MS. WELLS: Well, in the waiver world, you have to document what you did.

MS. DYER: You do in every world, but that's not progress toward the goal.

MS. WELLS: But you can't just check off. There's no progress toward goals in HCB because most individuals are more maintenance.

MS. DYER: Well, that's what somebody within your group - and I won't name them here but I will share that with you later - said.

MS. WELLS: Okay. So, they might have used the wrong terminology.

MS. DYER: Okay. That's what I'm trying to clear up.

MS. WELLS: So, they probably used wrong terminology because most of the time, HCB components are not--there's not a progression, regression or maintenance that is found in the other waivers. That's not a part of this particular waiver and we have that in the regulation, but the provider, the direct service provider - the

attendant, respite worker - on the PDS side or the traditional is going to have to document what they have done, their time in/time out, all of that and also talk to the component of providing some choices to the individual.

So, in the attendant care training, we spoke to that about the documentation. Final rule requires the participant to have some choices.

MS. DYER: But wouldn't that come from the case manager, not the person delivering the care? See, these are non-skilled, non-licensed people. They can't offer choices. They can say do you want a shower today or do you want a bed bath.

MS. CARTRIGHT: But if you don't have an order for it or it's not on the plan----

MS. WELLS: So, you've got to remember, you're mixing two world here, ladies.

MS. DYER: So, we'll have to have an order. We've already worked that out within our agency. We have to have an order to even schedule. So, that's a whole different world that you all don't live in but we have to.

MS. WELLS: But I think you have to remember there's just a component that service documentation is required for anyone providing any type of service for a waiver participant.

MS. DYER: So, we're going to have to have guidance on exactly what you expect.

MS. WELLS: And that's within the attendant care training, but I'll be glad to talk with you or your agency about all of that.

MS. DYER: And we'll go over that because we cannot have non-licensed people documenting toward progress.

MS. WELLS: Right. And, so, whoever--you know, whether it was me - you can call me out if it was. It's all right. You know I'll own it.

MS. DYER: It wasn't you. It wasn't you. I don't even know their full name.

MS. WELLS: So, I'll own it. You know I'll own it, but----

MS. DYER: But that was concerning.

MS. WELLS: No. We are not required--in the self-direction rules, we did

require that initially over the years, but because it was a standard in most all other waivers of progression, regression and maintenance of goals, but that is not a component of HCB's but they will have to document that they worked on those goals because that's the service that they're providing. I mean, surely your aides know what the person-centered----

MS. DYER: They can work on the plan of what's assigned.

MS. BRANHAM: They can work on a plan but not a goal.

MS. WELLS: Right. That is the plan.

MS. FLYNN: I think you're saying the same thing. As I listen to you, I think you're saying the same thing.

MS. DYER: But we're calling it different but this is not a goal. It's part of the plan, the components of a plan.

MS. FLYNN: The plan says three baths and then the worker - now, you correct me if I'm wrong - the worker goes out and says gave Jean a bath----

MS. DYER: And that's it.

MS. RUSSELL: Checks the box and moves on.

MS. DYER: But they can't evaluate that. That's the word I'm trying to say. They're not allowed to evaluate that.

MS. FLYNN: To maintain cleanliness. Gave Jean a bath to maintain cleanliness or gave Jean a bath. I'm not sure which is okay.

MS. DYER: A case manager that's assigned could evaluate that goal but our worker can't. So, it probably is terminology that is different.

MS. WELLS: I think so. I think one of the things, and I know that it's very blurred in conversations that we've had, Billie, the skilled side and the waiver side.

MS. DYER: But we've learned to talk through some of that.

MS. WELLS: We are and we sometimes need an interpreter, right? But I think one of the things that--you know, obviously you're licensed and a lot of this comes down to your licensure and making sure, but the skilled side is very different than the waiver side and we have to

remember that. Obviously your license is involved in that and you have to ensure that you're meeting your licensure component.

So, as we have spoken before, as a licensed entity, you will do what you need to do to ensure that you feel that you're meeting those standards; but in waiver, there are components. As you know, it's non-medical, non-skilled services but there are some components that we are required to fulfill and ser1vice documentation is one of them.

MS. DYER: Well, in a skilled side, an aide has to mark what they do. I mean, that's part of it and that's part of the care plan for the aide. That's her implementation. The evaluation would come from whoever goes in, not the person actually giving the bath.

MS. WELLS: The case manager in waiver is responsible to ensure that the person-centered plan is being met; and if it's not, they will need to address that, yes.

MS. STEWART: Where are we with getting a reg that says waiver is exempt from the licensure requirements?

MS. WELLS: That's a conversation we have been having, but at this time,

the regulation is not going to be opened, but it is something that we have been discussing because your licensure components are very stringent compared to what waiver components involve. And, so, sometimes it doesn't match up well, as Billie and I have discussed on many occasions.

MS. BRANHAM: Well, the CON was just written in there that your CON doesn't have anything to do with what you are providing.

MS. WELLS: We're working on that and recognize that there needs to be more clear for you all not to impact your licensure and the federal rules that you all fall under with that as well as the State, yes.

MS. DYER: Because right now we have to live under those.

MS. WELLS: Absolutely, yes. And OIG will make sure that you do, correct?

MS. DYER: Yes.

MS. STEWART: I've got one other thing, and if the Anthem person is still on the phone. I'm with ARH and we're still getting denials for--we're the only provider in Perry and Morgan County and we're getting denials from you all because we're not participating, and we accept non-

participating rates in order to protect our CON. So, you can't deny us. They can't require another provider to come in there if we're willing to do the work at a non-participating rate.

MS. RYAN: I can give you the provider rep that you would need to contact on that, but what is the name of your agency?

MS. STEWART: Appalachian Regional Healthcare.

MS. RYAN: And you said it was Perry and Woodford?

MS. STEWART: Perry and Morgan.

MS. RYAN: Morgan. Okay. And what is your name?

MS. STEWART: Susan Stewart.

MS. RYAN: I'll touch base with the provider rep and then we'll get back with you.

MS. STEWART: Okay. Thank you.

MS. BRANHAM: If there are no further discussion since they're ready to come in our room, our next meeting is scheduled for November 16th.

MS. CARTRIGHT: That was supposed to be rescheduled. We talked about that.

MS. BRANHAM: We need to work on a reschedule date. Terri is busy that morning from 8 until 11 with another TAC and our Home Health Conference is that day as well. So, Robbie, should you and I look together about trying to get us an alternate date and then putting it forward?

MR. EASTHAM: That would be fine. We can just get that together and send it out if it's acceptable once we come up with one.

MS. BRANHAM: All right. If there is no further discussion, the meeting is adjourned. Thank you.

MEETING ADJOURNED